SHIC talk

A program of the ND Insurance Department - Adam W. Hamm-Insurance Commissioner

February 2008

Adam W. Hamm
Insurance Commissioner

Commissioner 's Comments

Dear Friends:

2008 has proven to be busy at the Insurance Department as I am sure it has been in your homes and communities.

Since I last wrote, I have been devoting an enormous amount of time to meeting with many entities, including health insurance policyholders, insurance companies and medical providers. Some of the common themes and areas of concern seem to be rising health care costs, lack of insurance coverage and provider reimbursement rates.

Please know that adequate, affordable healthcare coverage for EVERYONE in North Dakota is a great concern to my staff and me. Over the next year we will be doing more research on this issue and formulating new ways in which we can improve accessibility to a variety of insurance options.

In the next year, I am also determined to meet more North Dakotans to better learn what the highest priority insurance issues are in our state. I want to extend an offer to visit your community to speak to your organizations, clubs, agent groups, health care entities, etc. Please contact our office if you or someone you know is interested in speaking with me. Our number is 1-800-247-0560. I hope to see you at an event soon!

Please accept my wishes for good health and much happiness for the New Year.

Adam W. Hamm
ND Insurance Commissioner

NORTH DAKOTA
a program of the North Dakota Insurance Department

SHIC
Senior Health Insurance Counseling

Questions to Ask Before Joining a Medicare Advantage Plan

Some people with Medicare choose to enroll in Medicare private health plans, sometimes called Medicare Advantage plans, rather than stay in Original Medicare. These private health plans contract with Medicare and are paid a fixed amount to provide Medicare benefits. They can be a managed care plan, the most common types being the Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO), or a Private Fee-For-Service (PFFS) plan.

Not all private plans—even plans of the same type—work the same way. For example, while HMOs provide no coverage if you go out of network (except in emergencies), some do cover some portion of your costs if you see out-of-network doctors. **Before you join a Medicare private health plan, make sure you understand that specific plan's network rules.**

If you already have a Medicare private health plan and want to switch to another one, you should do so **without disenrolling from your old plan**. It is best to enroll in the new plan by calling 800-MEDICARE, rather than by calling the new plan.

These are questions you should ask your doctor, friends, family members, and health plan representatives when looking into what a particular plan offers you.

Coordination with Other Benefits

How does the plan work with my current coverage?

If I join, could I lose my retiree/employer health coverage?

Doctors, Hospitals and Other Health Care Providers

Will I be able to use my doctors? Are they taking new patients in this plan?

Do my doctors recommend joining this plan?

What will happen if my doctors leave the plan?

Which specialists, hospitals, home health agencies and skilled nursing facilities are in the plan's network?

Access to Health Care

Who can I choose as my Primary Care Physician (PCP)?

How long will I have to wait for an appointment with my PCP or a specialist?

How easy is it to get referrals to see specialists? How long does a referral last?

Does my doctor need to get approval from the plan to admit me to a hospital?

Does the plan provide an incentive for my doctor to deny or reduce services? For example, does it cost my doctor money if she provides costly services to me?

If I have or develop a complex illness, what disease-related services are covered?

Extra Benefits

What extra benefits does the plan offer? What rules do I have to follow to get them?

Are there limitations on the extra benefits? How much do I have to pay for them?

o Physical exams
o Dental services
o Vision care
o If I need a certain type of treatment, will the plan cover it?

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Prescription Drug coverage

Are my prescription drugs on the plan's formulary (list of covered drugs)?

Are there any restrictions on when the plan will cover my prescription drugs, like step therapy, prior authorization or quantity limits?

Do I have to pay a deductible before the plan will cover my drugs?

How much will I pay for brand-name drugs? How much for generic drugs?

Will the plan cover my drugs during the coverage gap?

Will I be able to use my pharmacy? Is it in the plan's network? Can I get my drugs by mail order?

Can I fill my prescriptions if I travel away from the plan's network?

Cost

Do I have to pay a monthly premium? If so, how much is it?

How much is my co-payment for a visit with my PCP or a visit with a specialist?

How much will I pay for a hospital stay?

How much will I pay if I use a non-network doctor or hospital?

Are there higher co pays for certain types of care, such as hospital stays or cancer treatment?

Is there an annual out-of-pocket maximum? (After you spend a certain amount will your care be free or very low-cost?) Are all services included in the out-of-pocket maximum?

Service Area

What service area does the plan cover? How satisfied are other members?

What kind of coverage do I have if I travel outside of the service area?

Article Examines Medicare Financing and LTC Fiscal Outlook

For more than 40 years, Medicare has provided access to health care services for older Americans and people with disabilities. The program last year spent about $440 billion to serve an estimated 44 million people across the country. But the rapid growth in the nation's health care expenditures and overall demographic trends pose a challenge to Medicare's future financing.

A new issue brief prepared for the Kaiser Family Foundation provides an overview of Medicare's financing and the fiscal challenges the program faces in the coming decades. The brief describes how Medicare is financed and examines several methods of assessing its long-term financial outlook. It also looks at what is driving the program's growth, including the nation's broader trend toward higher health care costs.

Other contributing factors include the nation's aging population, the recently added Medicare drug benefit and growing enrollment in private Medicare Advantage plans. Lastly, the brief describes potential changes in the Medicare program that could arise if current trends continue and the potential for various policy proposals to change the trend lines, both for Medicare and for the nation's overall health-care spending. For more, look for *Financing Medicare: An Issue Brief* at www.kff.org/medicare/.

Does Medicare Pay for Outpatient Mental Health Services?

Yes, Medicare Part B helps pay for some outpatient mental health services. The services Medicare covers include:

- Individual and group therapy
- Family counseling to help with your treatment
- Tests to make sure you are getting the right care
- Activity therapies, such as art, dance or music therapy
- Occupational therapy
- Training and education (such as training on how to inject a needed medication or education about your condition)
- Substance abuse treatment
- Laboratory tests
- Prescription drugs that you cannot administer yourself (such as injections from a doctor)

You can get mental health services in an outpatient hospital program, a doctor's or therapist's office or a clinic. **Medicare will help pay for outpatient mental health services you receive from:**

- general practitioners
- nurse practitioners
- physicians' assistants
- psychiatrists
- clinical psychologists, social workers and nurse specialists

Medicare will only pay for the services of **non-medical doctors** (such as psychologists and clinical social workers) if the providers are **Medicare-certified and take assignment**, meaning that they accept Medicare's approved amount as payment in full. Medicare will pay for the services of **medical doctors** (such as psychiatrists) who do not take Medicare assignment, but these doctors can charge you up to 15 percent above Medicare's approved amount.

2008 Information for Low Income Subsidy and Late Enrollment

The national average monthly Part D premium for 2008 is $27.93. (This is the number used to compute late enrollment penalties.)

For counseling purposes, a "de minimis" (disregard) of $1.00 is added to the national average premium, the total must not exceed $31.61. Beneficiaries who receive full low-income subsidy "extra help" and enroll in a standard prescription drug plan with a premium less than the $31.61 benchmark will pay no monthly premium.

CMS Eliminates Part D Penalty for LIS Eligible in 2008

In October 2007 , CMS announced the elimination of the 2008 late enrollment penalty for any beneficiary found eligible for the low-income subsidy when enrolling in a Medicare drug plan.

Medicare Part A/B Deductible and B Premium Changes for 2008

The deductible for Part A is $1,024.00. The deductible for Part B is $135.00

The standard Medicare Part B monthly premium will be $96.40, an increase from $93.50 from 2007. However, if a beneficiary's income is greater than the legislated threshold amounts ($82,000 for a single beneficiary and $164,000 for a joint tax return) the beneficiary is responsible for a larger portion of the Part B benefit coverage.

Case Scenario for Quality Assurance

Recently, CMS has asked each SHIP to determine how they were going to provide quality assurance to their beneficiaries in their state. CMS's goal is to ensure that beneficiaries receive accurate, reliable and unbiased information. Due to this CMS request, in each newsletter we will provide a case scenario that we will share as a learning tool for ongoing education and consistency in problem solving. If you have a personal example that you would like to share, email csheldon@nd.gov.

L.B. had received an air ambulance bill (Part B) from his provider 'denied by Medicare as not medically necessary.' L.B had been in the hospital and was fighting a stomach aneurism that could have exploded at any time. The local physicians were not comfortable operating on his aneurism due to his fragile state. He was in an immense amount of pain, so severe he was hallucinating. The local physicians determined to send him to a larger medical facility. He was transferred by air ambulance. In his documentation it was stated that the patient had uncontrollable pain. It was also determined that he did sign an Advanced Beneficiary Notice.

L.B. and the SHIC caseworker completed the Carrier Reconsideration forms and filed them. The Carrier Reconsideration was denied and the result was, "denied due to services not being medically necessary."

At this point, the medical provider appealed the decision. The next step to appeal was to the Administrative Law Judge (ALJ). The date of trial had been set. Two weeks before the actual trial, the ALJ called the beneficiary, medical provider , and SHIC case manager and stated Medicare was fully responsible to the medical provider as the procedure was medically necessary. Based on documentation provided to the ALJ, no trial was necessary.

This appeal recuperated over $10,000 for the beneficiary. If you are not comfortable assisting with appeals, Legal Services of North Dakota may be able to help. They can be reached at 1-800-634-5263.

Director's Corner

I hope everyone has made it through the Part D Annual Enrollment in one piece! It was a busy time, but I know we helped many individuals make an educated choice with their prescription drug plan. Thank you for your help.

Medicare Advantage (MA) season is upon us and there are more plans than ever to choose from. This is a *good* thing as beneficiaries may find a plan that is more compatible with their individual needs.

I also wanted to take the opportunity to thank the statewide counselors for helping us with our data collection this year. It has definitely paid off! We have received a performance award from CMS in the amount of $25,000. This was a reward for our reporting the number of beneficiaries served. What we did we do with this money? We hired a part time staff member to assist us with the elevated needs of Medicare beneficiaries. This will be a benefit to everyone as we will have a greater capacity to serve all beneficiaries. Her name is Jan Frank and she comes to us from Medcenter One in Bismarck. Jan was the Patient Assistance Program director for years.

We are very lucky to have Jan's knowledge and skills here at the department. Her contact information is janfrank@nd.gov or she can be reached at 701-328-9611. Please feel free to call her if you have questions

Lastly, we have not set up our recertification/update training for the spring due to scheduling difficulties with IVN. We will provide that information shortly. See you soon!

Cindy Sheldon

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If you have questions about any content or have suggestions for content for our next publication, please contact Cindy Sheldon, Director, at 701.328.9604 or csheldon@nd.gov.

For Medicare related resources, please visit:

www.healthassistancepartnership.org/